

963

STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

State File No. 816

Registrar's No. 1289

1. Place of Death: (a) County Maricopa (b) City or Town Phoenix (c) Location St. Joseph Hospital
(If outside city limits also write RURAL) (St. & No. (or) Name of Institution)
(d) Length of Stay: In Hospital or Institution 7 weeks; In Community 24 years; in Arizona 24 years
(Specify whether years, months or days)
2. Usual Residence of Deceased: (a) State Arizona (b) County Maricopa (c) City or Town Phoenix
(If outside city limits also write RURAL)
(d) Street No. 1507 West Fillmore (e) Citizen of foreign country (yes or No) No
3. (a) FULL NAME Mary Cecilia Whalen (b) If Veteran name war No (c) Social Security No. 931

4. Sex Female 5. Color or Race White 6. (a) Single, married, widowed or divorced Single
6. (b) Name of husband or wife --- 6. (c) Age of husband or wife, if alive 0 yrs.

7. Birthdate of deceased July 16, 1890
(Month) (Day) (Year)
8. AGE: Years 53 Months 1 Days 8 If less than one day hrs. --- min. ---

9. Birthplace Kansas City, Mo
(City, town or county) (State or Country)

10. Usual Occupation At Home

11. Industry or Business ---

Father { 12. Name Joseph Whalen

13. Birthplace Pottsville, Pa
(City, town or county) (State or Country)

Mother { 14. Maiden Name Catherine O'Connell

15. Birthplace Ireland
(City, town or county) (State or Country)

16. (a) Informant's own signature Mrs. Catherins Van Horn

(b) Address 728 W. Portland

17. (a) Burial, Cremation or Removal Burial

(b) Place St Francis (c) Date Aug 27, 1948

18. (a) Embalmer's Signature Leo Nussbaum

(b) Funeral Director Whitney Funeral Home

(c) Address Phoenix, Arizona.

19. (a) AUG 26 1948 (Date received local Registrar)

(b) [Signature] (Registrar's Signature)

20M 100% Rag 8-42 B. Co.

County File No.

Date Received

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) 8-24-43, 19 43
TIME (Hour and minute) 1:10 P.M.

21. I hereby certify that I attended the deceased from July 1, 19 43 to Aug 24, 19 43
that I last saw him alive on Aug 24, 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to hypertension & brain disease
Due to ---

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations ---

Of autopsy Refused

22. If death was due to external causes, fill in the following:

(a) Accident, suicide or homicide (specify) ---

(b) Date of occurrence ---

(c) Where did injury occur? (City or Town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury ---

23. Signature [Signature] Address 15 E. McDowell Date signed 8-25-48

DURATION

1 day

1 year

PHYSICIAN

Underline cause to which death should be charged statistically